

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 September 2006

CASE NO.: 2004-BLA-05609

In the Matter of:

J.O.,

Claimant,

vs.

ENERGY WEST MINING, INC.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances: Jonathan Wilderman, Esquire
For Claimant

William S. Mattingly, Esquire
For Employer

Before: Jennifer Gee
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

INTRODUCTION

This case arises from a claim for benefits under the “Black Lung Benefits Act,” Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (hereinafter referred to as “the Act”), and applicable federal regulations, mainly 20 C.F.R. Parts 410, 718 and 727 (“Regulations”).

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.¹

¹ The following abbreviations have been used in this opinion: DX = Director’s exhibit, EX = Employer’s exhibit, CX = Claimant’s exhibit, TR = Transcript of the hearing, BCR = Board-

A formal hearing was conducted in Price, Utah on October 12, 2005, at which all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations.²

For the reasons set forth below, the Claimant is awarded benefits.

ISSUES

The contested issues in this case are:

1. Whether Claimant demonstrated a material change in conditions pursuant to § 725.309;
2. Whether Claimant has pneumoconiosis;
3. Whether the pneumoconiosis arose out of Claimant's coal mine employment;
4. Whether Claimant has a totally disabling pulmonary impairment; and
5. Whether the total disability was due to pneumoconiosis. (TR 6-7.)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background³

Claimant apparently filed his first claim for Black Lung benefits on March 31, 1980.⁴ (DX 39.) It was noted in a memo to the Office of Workers' Compensation ("OWCP") file that the records from this first claim were destroyed. The memo stated that although benefits were denied, "evidence showed that Mr. Oliver had coal worker's pneumoconiosis arising out of his over-10 years of coal mine employment, the evidence did not show that Mr. Oliver was disabled

certified radiologist, BCI = Board-certified internist, B = B reader, and CWP = coal workers pneumoconiosis.

² At the hearing, Director's exhibits 1 through 42 (TR 6), Employer's exhibits 1 through 13 and 15 through 17 (TR 22), and Claimant's exhibits 1 through 12 (TR 10) were admitted into evidence. At the hearing, I reserved ruling on Employer's exhibit 14 which consisted of responses from Dr. Lawrence to interrogatories from Employer. On January 31, 2006, I issued an Order admitting said exhibit finding that Dr. Lawrence's responses did not constitute a reading of a chest x-ray as argued by Claimant. The record was left open for the submission of the deposition transcripts of Drs. Fino (EX 17) and Farney (EX 16) and closing briefs. Employer filed its closing brief on January 4, 2006, and Claimant filed his closing brief on January 3, 2006.

³ Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (i.e. March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in Utah this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Tenth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 B.L.R. 2-369 (10th Cir. 1998).

⁴ In his application for benefits, Claimant stated that this was his first filing for benefits. However, counsel for Claimant in his opening statement stated that Claimant had filed a previous claim in 1980 while still a miner. (DX 2; TR 28.)

by the disease at that time.” No further action was taken on this claim and it was subsequently closed. (DX 39.)

Claimant filed his second claim for benefits on February 15, 2002. (DX 2.) On May 23, 2003, the District Director issued a Proposed Decision and Order - Awarding Benefits. In that decision, the District Director found Claimant had established 22 years of coal mine employment, that as a result of his coal mine employment the miner had contracted pneumoconiosis, and that the miner was totally disabled by his pulmonary condition. (DX 32.) Employer disagreed with the determination and requested a formal hearing. (DX 33.)

Claimant was 77 years old at the time of the hearing and was married to his wife, Carol until her death on July 13, 2005. (TR 37, 7.) Claimant worked for Energy West from October 1967 to 1993. (TR 38.) He worked in two underground mines in Utah, the Des-Bee Mine and Deer Creek Mine. (TR 39.) Claimant worked as a shuttle car operator at the face of the mine where the coal was actively being mined. While working in that job, he could see coal dust in the air, which looked cloudy. (TR 40-41.) Claimant also worked as a belt man and was often exposed to coal mine dust. (TR 42.) Claimant’s last coal mine employment was as a bath house man from 1986 to 1993. (TR 43.) Claimant’s job was to clean the bath house during an eight hour shift. (TR 43.) He would have to clean up after 150 miners. (TR 44.) Claimant’s duties included mopping floors and scrubbing the bathroom and shower areas. (TR 44, 73.) He observed that there was a lot of coal dust flying around the bath house and that coal dust from the miners’ clothes and boots accumulated on the areas he cleaned. (TR 45.) Coal dust would accumulate on his work clothes and his body. (TR 46.) As part of his job, Claimant would have to carry large buckets of water for mopping weighing about 20 pounds. (TR 47.) He also had to lift boxes of detergent weighing about 30 pounds. (TR 48.) In the winter Claimant had to shovel snow and carry 30 pound garbage bags from the bath house to the garbage bin. (TR 48.) Claimant spent the entire shift on his feet. (TR 49.)

Claimant stacked detergent about twice per week, and it would take him about an hour to complete that task. (TR 55-56.) He would have to carry bags of garbage over his shoulder and his mop bucket did not have wheels. (TR 56.) Claimant felt his greatest coal dust exposure was as a shuttle car operator, then the belts, and the lightest exposure was in the bath house. (TR 57-58.) Claimant broke both legs in December 2004 when a calf fell on him. (TR 59.) He was unable to walk for two months but was fine at the time of the hearing. (TR 59.) Claimant was hospitalized in the fall of 2004 for pneumonia. (TR 61.) Claimant did not see a big difference in his breathing after using an inhaler. (TR 66.)

Lee McElprang worked with Claimant in the mines. (TR 68.) He was the mine operator when Claimant was the shuttle car operator. (TR 68.) He noted that the Des-Bee Dove Mine was a dry mine and was really dusty. (TR 68.) He found the Des-Bee Dove Mine was so dusty that a mine operator could not see the shuttle car by the time it was loaded with coal. (TR 69.) At the Deer Creek Mine, Mr. McElprang was mostly a construction foreman. (TR 69.) The Deer Creek Mine was a two-entry system with belt lines that were really dusty. (TR 70.) Mr. McElprang worked at the mine at the same time Claimant worked as a bath house attendant. Mr. McElprang expressed the opinion that he would rather work in the mine than the bath house because the bath house was a filthy place. (TR 72.) Mr. McElprang observed coal dust everywhere in the bath house. (TR 72.)

At the time of the hearing, Claimant was on oxygen on a 24 hour basis. (TR 49.) The oxygen was prescribed by Dr. Morgan, his treating physician since 1995. (TR 49.) Claimant was on Advair for his breathing. (TR 49.) He noted that bronchodilators did not provide much help for his breathing. (TR 50.) Claimant coughed all of the time. (TR 50.) His granddaughter, Juanita Oliver, who lived with him, saw his coughing episodes in the mornings that brought up large quantities of phlegm. (TR 78-79.) He would become short of breath when walking and had to install a ramp in his house because it was easier than going up steps. (TR 51, 77.) His granddaughter did most of the work around Claimant's house. (TR 77.) He had a hard time lifting things and took naps every day. (TR 77-78.) Claimant believes his respiratory symptoms have gotten worse. (TR 53.) Claimant has never been told he has asthma. He does not have difficulty swallowing food. (TR 53-54.) Claimant had prostate cancer in 1995 and had a pace maker installed in 1998. (TR 54.)

Medical Evidence

Chest X-rays

Exhibit Number	Date of X-ray	Physician/Qualifications	Diagnosis
DX 12	7-21-95	Baldwin	Mild cardiac enlargement w/mild chronic congestive heart failure; 2cm x 5mm calcified density in right apex
DX 12	9-6-95	Wing/ Utah Valley Regional Medical Center	Prominence of right hilum appears due to vessels rather than mass; no pulmonary nodules; old rib and clavicle fractures
DX 12	8-9-96	Watts/ Utah Valley Regional Medical Center	No acute pathology, no metastatic prostate disease; lungs clear of infiltrate, some bibasilar atelectatic changes
DX 12	3-3-98	Sheya/ Castlevew Hospital	Mild bibasilar scarring and osteoporosis; atherosclerosis
DX 19	3-3-98	Hayes/ BCR, B	0/0, linear areas of subsegmental fibrosis and scarring
DX 12	3-4-98	Baldwin/ Castlevew Hospital	Healed fracture left clavicle; interval placement of sequential pacemaker
DX 12	4-1-98	Sheya/ Castlevew Hospital	Interval placement of nasogastric tube; bibasilar atelectasis

DX 12; CX 6	6-15-01	Sharma	HX: pain between shoulder blades; no acute pulmonary disease; stable fibrotic changes within LL base suggestive of hiatal hernia
DX 18	4-26-02	Preger/ BCR, B	Film Quality 1
DX 17 ⁵	4-26-02	Lawrence/ BCR, B	1/2, s/s, 4 zones
EX 10	4-26-02	Wiot/ BCR, B	Negative for CWP
EX 2; CX 6	3-24-03	Morrison/ BCR, B	Emphysema and chronic pulmonary hypertension; bilateral bibasilar mild interstitial fibrosis; cannot exclude scarring secondary to chronic aspiration
CX 4, 6	8-24-04	Collins	2-3 mm speculated appearing density in right mid lung area not previously seen; chronic changes w/o significant amount of change compared to previous films
CX 1	8-24-04	James/ B	0/1, s/t, 2 zones
CX 6	10-5-04	Taylor/ Castlevue Hospital	Bibasilar interstitial prominence and LLL infiltrate
CX 6	10-6-04	Hammond/ Castlevue Hospital	F/U Pneumonia; perihilar lung disease; LLL atelectasis; opacity in right costophrenic sulcus possibly related to aspiration or pneumonia
CX 6	10-7-04	Kendell/ Castlevue Hospital	F/U Pneumonia; improvement in cardiac size and pulmonary infiltrates since yesterday; may represent some improvement in CHF
CX 6	11-16-04	Kendell/	F/U Pneumonia; improved

⁵ On July 5, 2006, Dr. Lawrence responded to interrogatories issued by Employer regarding his reading of this chest x-ray. He indicated that these findings could be seen in CWP, asbestos workers, polyvinyl/chloride workers, ex-miners and that is was “chronic, not necessarily occupational pulmonary fibrosis.” He added that no radiographic findings are “pathogenomonic [sic] of dust exposure.” Dr. Lawrence stated that the length of exposure as well as exposure to other dusts and cigarette smoking could influence findings on a chest x-rays and that he was sent films with no history. (EX 14.)

		Castleview Hospital	pleural fluid and bilateral infiltrates since 10-7-04
CX 1	5-6-05	Delacey	HX: shortness of breath; linear opacities in LLL most likely scarring; acute infiltrate less likely but not excluded

CT scans

Exhibit Number	Date of CT scan	Physician/Qualifications	Diagnosis
EX 2; CX 6	3-24-03	Morrison/ BCR, B	Compatible w/COPD, associated w/pulmonary hypertension, hiatal hernia w/some compression atelectasis in LLL, mild interstitial fibrosis, possibility of chronic aspiration, no evidence of acute pneumonia, no evidence of pleural plaque formation
EX 4	3-24-03	Fino/ B	Calcified left hilar lymph nodes, no evidence of bilateral basilar fibrosis
CX 5, 6	9-1-04	Taylor	Probable benign post inflammatory changes, follow-up in 4 months

Pulmonary Function Studies⁶

Exhibit	Date	Age	Height	FEV 1	MVV	FVC	Qualify?
CX 6	3-25-99	71	65"	1.81	68	2.71	No

⁶ Due to the discrepancy in height, qualification of the vent studies is based on an average height of 64.25 inches. The measurement of 61" from the May 6, 2005, study is three inches less (64") than the study that was performed about one year prior. Clearly this measurement is in error and will be discarded in the calculation of the average height in determining whether the vent values are qualifying under the Regulations.

DX 16	5-8-02	74	65"	1.94 *2.00	---- ----	2.83 *2.76	No No
EX 2	3-24-03	75	63"	1.93 *2.16	37 ----	2.84 *3.16	No No
CX 3 ⁷	2-10-04	76	64"	1.12 *1.65	---- *35	1.82 *2.46	Yes No
CX 1 ⁸	5-6-05	77	61"	1.74 *1.99	57 ----	2.54 *2.82	No No

*Post-bronchodilator

Arterial Blood Gas Studies

Testing on April 26, 2002, and March 24, 2003, was performed at 3000 to 5999 feet above sea level. (DX 14; EX 12, p. 35; EX 13, p. 52; EX 16, p. 15.) Therefore, the values in table (2) under Appendix C to "Part 718 – Blood-Gas Tables" will be used in determining whether Claimant's arterial blood gas values are qualifying under the regulations.

Testing on May 6, 2005, was performed at 6700 feet above sea level. EX 15, page 27. Therefore, the values in table (3) under Appendix C to "Part 718 – Blood-Gas Tables" will be used in determining whether Claimant's arterial blood gas values are qualifying under the regulations.

Exhibit	Date	PO2	PCO2	Qualify?
DX 14 ⁹	4-26-02	60	35	Yes
EX 2	3-24-03	63	34.4	No
CX 1	5-6-05	57.7 *63.7	35.4 *32.4	No Yes

*Post-exercise

⁷ The technician noted that there was good effort but that Claimant developed a loose cough after bronchodilator that made exhalation difficult. Dr. Renn, who is Board-Certified in Internal Medicine and Pulmonary Disease, subsequently reviewed this study and listed seven reasons why said study was invalid. (EX 9.)

⁸ The technician noted that Claimant was a very difficult patient and that numerous attempts were made for maximum effort during the FVC testing. It was noted that Claimant had frequent cough especially with expiratory maneuvers. Dr. Renn reviewed this study and listed twelve reasons why this study was invalid. He also noted that a patient could not artificially improve his vent function so the numerical values represented vent function less than that of which Claimant would be capable were the study performed with complete cooperative effort. (EX 7.)

⁹ This study was reviewed by Dr. Kennedy who is Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Kennedy found that the study was valid. (DX 15.)

Medical Reports

Dr. Jean-Maurice Poitras

The medical report of Dr. Poitras is dated May 8, 2002 and appears at DX 13. Dr. Poitras examined Claimant at the request of the Department of Labor. Dr. Poitras is Board-Certified in Internal Medicine. (CX 11.) He reviewed Claimant's occupational history noting Claimant's last position as a bath house man from 1986 to 1993. A statement attached to the report stated that Claimant's exertional requirements of this job included standing for 8 hours and lifting 10-20 pounds and carrying for a distance of 1 to 15 feet as required. It was also noted that Claimant mopped floors, cleaned mine lights, and maintained and cleaned the bathhouse. Dr. Poitras took a family history that was positive for asthma. Claimant reported a medical history positive for frequent colds, attacks of wheezing, heart disease, and prostate cancer. Claimant had a pacemaker inserted in March of 1998. Claimant reportedly never smoked cigarettes. Claimant's chief complaints were cough with sputum production, wheezing, dyspnea, and orthopnea. Claimant was only on Tylenol. Physical examination of the lungs showed decreased breath sounds on auscultation with very slight wheeze. A chest x-ray showed several small opacities, a vent study showed mild to moderate obstructive lung disease, and arterial blood gases showed low-normal oxygenation and very mild respiratory alkalosis.

Dr. Poitras concluded Claimant had a mild to moderate obstructive lung defect based on pulmonary function studies and examination and coronary artery disease based on his ECG. It was noted that Claimant had questionable LLL opacities – "defer to B-reader." Dr. Poitras opined that with Claimant's negative smoking history, he "suspected" that coal dust exposure for 25 years played a role in the obstructive defect. He concluded that Claimant's obstructive defect coupled with the low normal PO2 would make physical activity such as that required of a mine/laborer impossible and would make Claimant 100% disabled. He added that the obstructive lung defect plus the low/borderline hypoxemia contribute 100% to the disability.

The deposition of Dr. Poitras is dated June 8, 2005, and appears at EX 13. Counsel for Employer noticed this deposition. On questioning from counsel for Employer, Dr. Poitras described the exertional requirements of a bath house attendant as light to moderate. Prior to the deposition he reviewed the medical report of Dr. Farney. He noted that there was a major difference in the pulmonary function testing in that his test showed only 2-3% reversibility whereas Dr. Farney's vent study showed 12% reversibility. He agreed that he would not expect to see reversibility associated with coal mine induced lung disease. He agreed that the post-bronchodilator values were on the lower side of normal. Dr. Poitras noted that Claimant might benefit from treatment with bronchodilators. Dr. Poitras agreed that CT scans were a superior radiographic method to determine the absence of pneumoconiosis such as this. Dr. Poitras did not make a diagnosis of pneumoconiosis from a radiographic standpoint. He agreed that Claimant's pulmonary disease was playing a fairly significant role in his complaints of shortness of breath. He agreed that part was also due to cardiac disease. He opined that someone with a resting PO2 of 60 would have difficulty doing any type of work that required lifting and even mopping. Dr. Poitras stated that Claimant's chronic obstructive pulmonary disease ("COPD") was due to many factors including coal mine dust exposure, chronic aspiration, and the fact that he was a rancher. He agreed that the opacities found on chest x-ray were not typical of coal mine dust exposure. Dr. Poitras attributed Claimant's COPD at least in part to coal mine dust

exposure because Claimant's significant amount of exposure to coal mine dust (17 years) could not be excluded and Claimant had no other significant exposures. Dr. Poitras stated that he would now diagnose Claimant as having chronic bronchitis based on symptoms. He agreed that the CT scans and chest x-rays did not support a diagnosis of pneumoconiosis.

On questioning by counsel for Claimant, Dr. Poitras stated that the Claimant's complaints, his findings on Claimant's physical examination, and the CT scan supported a diagnosis of COPD. He found no evidence consistent with a diagnosis of congestive heart failure. He agreed that the results of the May 8, 2002, vent study reflected the presence of a mild to moderate obstructive lung defect. He also agreed that Dr. Farney's vent study showed some degree of obstructive lung disease. Dr. Poitras stated that based on the pre-bronchodilator values of Dr. Farney's study there would be some impairment to doing physical labor. He agreed that Claimant's PO₂ of 60 would meet the criteria for disability under the regulations for an altitude of 3,000 to 5,999 feet. He also agreed that this low blood gas value could result from COPD. Dr. Poitras noted that after reviewing Dr. Farney's vent study he now believed that coal mine dust exposure played a significant, but partial, role in Claimant's mild to moderate disease. After reading Claimant's job description as a bath house attendant, Dr. Poitras agreed that if untreated Claimant would have difficulty performing all of the requirements of his job. He opined that Claimant's coal mine dust exposure was a significant contributing factor to both his lung disease and respiratory disability.

Dr. Robert J. Farney

The medical report of Dr. Farney is dated March 24, 2003, and appears at EX 2. Dr. Farney is Board-Certified in Internal Medicine and Pulmonary Disease. (EX 3.) Dr. Farney examined Claimant at the request of Employer. He also reviewed medical records including therapy records for prostate cancer, the medical notes of Dr. Morgan, and the medical report of Dr. Poitras. Dr. Farney reviewed Claimant's occupational history noting 24 years of coal mine employment. For the last 5-6 years, Claimant worked as a bath house attendant. He noted that the bath house was above ground and that Claimant's duties were janitorial. Claimant reportedly never smoked cigarettes. Claimant's chief complaints were shortness of breath on exertion and chronic cough productive of sputum. It was noted that Claimant had grossly audible rhonchi. Dr. Farney reviewed Claimant's social and family history which was positive for asthma. Claimant's medical history was positive for prostate cancer, bradycardia with pacemaker, esophageal spasm and dysphagia, peptic ulcer disease, and anemia. Physical examination of the lungs revealed diffuse coarse crackles in both bases, mild, expiratory wheezes, and deep breathing caused brief cough paroxysms. Arterial blood gases were performed and a vent study showed mild air flow obstruction with significant bronchodilator response. Although the chest x-ray was read as 1/0, Dr. Farney opined that based on the high resolution CT scan, the radiographic findings were consistent with non-specific fibrosis or scarring and inflammation associated with chronic aspiration.

Dr. Farney concluded Claimant suffered from COPD, mild, reversible with bronchodilators. He added that these findings were consistent with asthma or reactive airways disease. Other contributing factors included occult chronic gastroesophageal reflux and animal exposure (horse). He noted that vent studies showed a normal diffusion capacity which supports a diagnosis of reactive airways disease rather a diagnosis of emphysema/fibrosis. Dr. Farney

concluded that Claimant did not have coal worker's pneumoconiosis. He opined that Claimant's coal dust exposure was relatively modest noting that out of the 22-23 years, 5-6 were above ground in the bath house. He noted that the progression of symptoms subsequent to retirement from the coal mine without the concomitant fibrotic lung disease, the presence of reactive airways disease, and negative chest radiography, are all findings inconsistent with CWP. Dr. Farney concluded Claimant would be completely impaired and disabled from working as a coal miner due to various medical problems including carcinoma of the prostate, anemia, possible occult malignancies, reactive airway disease, fatigue, and age. He added that Claimant was not impaired from CWP and that Claimant would not be impaired from working due only to pulmonary disease.

The deposition of Dr. Farney is dated October 10, 2005 and appears at EX 16. After reviewing the job description of bath house attendant, Dr. Farney opined that it would require fairly minimal pulmonary function because it did not require continued sustained effort. He said that altitude and age must be considered in analyzing blood gas results. He noted that Claimant's response to bronchodilators was some evidence of reactive airways disease. Dr. Farney indicated that spirometry showed Claimant had good capacity for moving air in and that he had only a mild air flow obstruction that improved into the normal range after bronchodilators. He noted that he would expect the diffusing capacity and the FEV-1 to be low if there was significant pulmonary disease due to coal dust exposure. He stated that Claimant's pattern was consistent with asthma or nonspecific chronic bronchitis. He noted that he did not think that "the findings specifically make the diagnosis of asthma" adding that he thought they were very consistent with that diagnosis. Dr. Farney was not aware of coal dust causing reactive airways disease or reversible obstructive airways disease. He reviewed the medical report of Dr. James and opined that pre-bronchodilator showed mild obstructive airways disease and the post-bronchodilator was normal. He opined that the arterial blood gases were normal. Dr. Farney concluded that Claimant's ability was normal from a pulmonary standpoint. He opined Claimant did not have a chronic coal mine induced lung disease and that COPD was not causing pulmonary impairment. He stated that a high resolution CT scan was a more precise method of looking at the structure of the lung and it was more reliable than standard chest x-rays. He concluded Claimant retained the pulmonary capacity to perform the duties of bath house attendant.

On examination by counsel for Claimant, Dr. Farney disagreed that Claimant had sufficient coal mine dust exposure to develop COPD. He noted that Claimant's exposure was quite minimal. He noted that Claimant was not exposed to any coal dust while in the bath house and that his exposure on the belt line was intermittent. He clarified that Claimant's exposure to significant amounts of coal dust would be very low in the bath house. He agreed that he was not making this opinion based on any dust measurement data. He noted that it was highly improbable that one could develop COPD from the level of coal dust exposure described in this case.

Dr. Max Morgan

The medical report of Dr. Morgan is dated February 27, 2004, and appears at CX 2. Dr. Morgan stated that Claimant had been his patient since July 1995 and that he had been in the office frequently for shortness of breath, respiratory distress, wheezing, and recurrent upper

respiratory tract infections. Claimant used an inhaler as needed. Claimant's chief complaints were shortness of breath on exertion and at night when sleeping and early morning cough with sputum. As a result Claimant was unable to hunt, fish, or even take a casual stroll without shortness of breath. Moreover, Claimant was unable to do chores around the ranch. Physical examination showed distant breath sounds with few generalized expiratory wheezes evident. Claimant's extremities showed early clubbing. A recent vent study showed obstructive airway disease and serial chest x-rays showed fibrotic bands in the left base as well as diffuse bibasilar pulmonary scarring. Dr. Morgan concluded that Claimant had chronic obstructive disease with pulmonary fibrosis, pulmonary emphysema, and pneumoconiosis in light of pulmonary scarring and his 25 year history of coal dust exposure. Claimant also had underlying atherosclerotic cardiovascular disease with pacemaker rhythm and adenocarcinoma of the prostate. Dr. Morgan opined Claimant had an incapacitating breathing status and that he was handicapped and impaired by this disability.

The deposition of Dr. Morgan was taken on April 18, 2005, and appears at EX 12. The deposition was noticed by Employer. On examination by counsel for Employer, Dr. Morgan stated that the nature of his practice was family practice and limited general surgery. He stated that he treated patients with pneumoconiosis but had not taken on any other patients with that disease for the last 5-10 years. He added that he would defer to a radiologist or pulmonary specialist in interpreting chest x-rays for the disease. He noted that some patients with obstructive defects associated with coal dust exposure show some improvement with treatment with bronchodilators. Dr. Morgan stated that he began treating Claimant in 1995. He relied in part on the diagnosis of CWP by Dr. Poitras as well as various chest x-rays noting the presence of pulmonary nodules. He agreed that none of the chest x-rays or CT scans were read by a radiologist as being positive for coal worker's pneumoconiosis.

Dr. Morgan noted that Claimant's complaints of shortness of breath have varied. He agreed that shortness of breath can be a non-specific symptom. Dr. Morgan noted that Claimant was not in chronic heart failure and therefore not the cause of changes seen on CT scan. Dr. Morgan never diagnosed Claimant as having chronic bronchitis. Dr. Morgan agreed that Claimant's vent studies, including the FEV 1, improved with bronchodilators. Dr. Morgan stated that he would defer to a pulmonary specialist to determine whether a post-bronchodilator FEV 1 value of 79% was within normal range and whether it would be sufficient for performing manual labor from a pulmonary standpoint. He stated that Claimant was not prescribed bronchodilator medication following the February 10, 2004, vent study except for a limited time for treatment of pneumonia. He noted that normal values for blood gases change (decrease) with age. He agreed that Claimant's PO2 levels could be affected by his heart condition. Dr. Morgan based his diagnosis of COPD on the pulmonary function test, history of shortness of breath, and chest x-ray findings.

He opined that Claimant was totally disabled from multiple reasons but could not say that it was from pulmonary condition alone. After reviewing the exertional requirements of Claimant's last coal mine job as bath house attendant, Dr. Morgan stated that he did not think Claimant retained the pulmonary capacity to perform that kind of work. He felt that Claimant would become short of breath but did not know if that conclusion was compatible with the pulmonary function studies. He noted that Claimant would become short of breath walking from his car to the office and that what was seen on paper did not really indicate what someone could

do as far as physical capacity. He opined that half of Claimant's shortness of breath was due to pulmonary causes and the other half to cardiac problems. He agreed that he would defer to a pulmonary specialist in assessing whether Claimant had pulmonary disease. Dr. Morgan was familiar with Dr. Farney and agreed he was a competent pulmonary specialist.

On examination for counsel for Claimant, Dr. Morgan agreed that the arterial blood gas values of PO₂ of 60 and a PCO₂ of 35 were presumed disabled by the Department of Labor according to the regulations for an altitude of 3,000 to 5,999 feet. Dr. Morgan stated that he had been treating Claimant since 1995 for various medical conditions including his respiratory problems. Dr. Morgan treated Claimant on a fairly regular basis and had attended to Claimant during hospitalizations. He ordered tests for Claimant and had reviewed lab results for his medical conditions. He noted that Claimant's symptoms and exam findings were compatible and consistent with COPD. Dr. Morgan stated that Claimant's FEV-1 on February 10, 2004, although improved, was still abnormal after bronchodilator treatment. He confirmed that the May 8, 2002, vent studies were abnormally low, reflecting a respiratory impairment. Dr. Morgan agreed that Claimant's 22 years of coal dust exposure was more than a minimal contributing factor to his COPD. Dr. Morgan noted Claimant was a cattle rancher and that gathering cattle in the range was a dusty environment as well. Dr. Morgan agreed it was a strong possibility that cattle ranching contributed to Claimant's COPD. Dr. Morgan agreed he never diagnosed Claimant as having asthma or allergies. Dr. Morgan agreed that based on arterial blood gases, Claimant had hypoxemia and that he prescribed oxygen therapy for Claimant. He also agreed that this showed an impairment of oxygenation of blood by his lungs and reflected the presence of a respiratory impairment and disability. He opined that Claimant's COPD was a significant contributing factor to Claimant's hypoxemia. He agreed that Claimant, from a respiratory standpoint, was unable to perform the duties of his last coal mine employment. Dr. Morgan opined Claimant had COPD that was significantly related to his dust exposure in coal mine employment. He added that this disease made a strong contribution to Claimant's inability to perform his last coal mine job.

Dr. Gregory Fino

The medical report of Dr. Fino is dated August 17, 2004, and appears at EX 4. Dr. Fino is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader of chest x-rays. (EX 5.) Dr. Fino conducted a medical record review at the request of Employer. He reviewed Claimant's occupational history noting 25 years of coal mine employment. He reviewed and summarized medical records including the medical notes of Dr. Morgan, medical report of Dr. Farney, and a chest x-ray and CT scan from March 24, 2003. It was noted that Claimant was not a smoker. It was also noted that Claimant's last job was in the bath house.

Dr. Fino concluded that there was insufficient evidence to justify a diagnosis of pneumoconiosis. He stated that there was a mild, reversible respiratory impairment present and that he suspected that it was due to asthma and not coal dust. He opined Claimant was not disabled from returning to his last coal mine job from a respiratory standpoint. He noted that an FEV 1 of 75% is adequate lung function to perform his job as bath house attendant. He added that improvement following bronchodilators was really not consistent with a coal dust related pulmonary condition and that CWP was not reversible. Dr. Fino stated that even if the abnormality on lung function was CWP, Claimant was not disabled. Dr. Fino added that there

was no evidence of oxygen transfer abnormality as the diffusing capacity was normal. He noted that arterial blood gases in people in Utah would be a lot lower than at sea level. He noted that both arterial blood gases were normal. Dr. Fino concluded that even if Claimant had pneumoconiosis, it had not caused any disability.

The deposition of Dr. Fino is dated November 3, 2005, and appears at EX 17. This deposition was notice by Employer. Dr. Fino noted that the pre-bronchodilator testing showed a mild airway obstruction but that there was complete reversal into the normal range after bronchodilators. He noted that the obstruction was unaccompanied by any lung destruction caused either by fibrosis or emphysema because the lung volumes were normal. He added that the diffusing capacity was normal. He concluded that based on spirometry, lung volumes, diffusing capacity, and exercise tests, that Claimant had a mild reversible airways obstruction that would not prevent him from performing considerable labor. He agreed that the arterial blood gases were normal when adjusted for age and altitude. He characterized the exertional requirements of Claimant's bath house position as moderate. He opined, based on the exercise study, that Claimant maintained enough exercise capacity to perform the bath house job. He disagreed with the conclusion of Dr. James that the exercise study showed decreased maximum exercise tolerance consistent with deconditioning and a component of vent limitation. Dr. Fino stated that obstructive impairment caused by coal mine dust exposure was not reversible and that coal mine dust could not cause asthma. He concluded Claimant did not have clinical or legal pneumoconiosis. He added that Claimant's ability to perform manual labor from a pulmonary standpoint was unrestricted based on exercise test and spirometry. He added that Claimant would be capable of performing moderate labor with bursts of heavy labor.

On questioning by counsel for Claimant, Dr. Fino agreed that the FEV-1/FVC ratio was consistent with obstruction. He agreed that Claimant had sufficient coal mine dust exposure to cause COPD. He stated that asthma had not been diagnosed in this case to his knowledge.

Dr. David S. James

The medical report of Dr. James is dated May 6, 2005, and appears at CX 1. Dr. James is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader of chest x-rays. (CX 10.) Dr. James examined Claimant for complaints of shortness of breath. He noted that Claimant had respiratory complaints for 20 years. Claimant had a cough productive of sputum and frequently had wheezing. Claimant's past medical history included being placed on supplemental oxygen at night in the winter of 2004. Claimant was never a smoker. Dr. James reviewed Claimant's occupational history noting that Claimant's last employment was as a bath house attendant. Claimant's duties included sweeping and mopping the floors, occasionally lifting 30 pounds, and maintaining the miners' head lamps. Claimant had a family history of asthma. Physical examination of the lungs showed cough with deep breaths, normal respiratory exertions, rhonchi bilaterally, no wheezes, clear to percussion. A vent study on May 6, 2005, showed moderate airflow limitation, air trapping and a chest x-ray from May 6, 2005, showed bilateral lower lobe irregular opacities, more prominent in the left base, mild in severity. Dr. James reviewed an additional chest x-ray, CT scan, lab data from 1999, and prostate cancer records from 1995.

Dr. James concluded that Claimant suffered from chronic obstructive lung disease, moderate in severity based on a history of 20 years of shortness of breath, productive cough, and moderate airflow on spirometry. He opined that asthma was an unlikely explanation for Claimant's respiratory changes. Claimant had airflow limitation that persisted despite bronchodilator challenge. Dr. James noted that Claimant's volume of phlegm production would be unusual for an individual with only asthma. He added that there was no evidence of bronchiectasis on plain film or CT scan and Claimant was never a smoker. However, Claimant did have significant exposure to coal mine dust over a 24 year period. He concluded that Claimant's exposure to coal mine dust was a contributing factor to the development of his COPD. Dr. James noted that chronic exposure to coal mine dust has been shown to be a risk factor for developing COPD and that there were no other occupational exposures that would have contributed to Claimant's development of chronic pulmonary disease.

Dr. James opined that Claimant's COPD was moderate in severity based on the decline in the FEV-1. He added that Claimant's lung disease was a contributing factor in his decreased maximum exercise capacity. He noted that Claimant did not meet DOL guidelines for disability for lung function or blood oxygen based on arterial blood gases. He noted that Claimant's job duties "were strenuous." However, it could not be determined at that time whether Claimant would be unable to perform his usual coal mine employment as a consequence of his lung disease.

Dr. James also diagnosed Claimant as having symptomatic bradycardia, abnormal sleep history, no evidence of fibrotic disease consistent with coal worker's pneumoconiosis, and decreased exercise tolerance secondary to deconditioning and to a component of vent limitation from COPD.

The deposition of Dr. James is dated October 3, 2004, and appears at EX 15. Counsel for Employer noticed this deposition. On questioning by counsel for Employer, Dr. James explained the use of digital x-rays and opined that they were adequate in determining whether a patient had changes consistent with pneumoconiosis. He noted that an advantage of digital x-rays was that one could enlarge regions of the image and could adjust the contrast/brightness. Dr. James reviewed notes from Dr. Morgan, various radiographs, and the medical reports of Drs. Poitras and Farney. He indicated that there were no specific findings on examination that would be consistent with cardiac disease. He examined Claimant at the request of Claimant's treating physician, Dr. Morgan. He rated the exertional requirements of Claimant's last job as mild to moderate and noted that this job could be performed with some pulmonary impairment. He indicated that Claimant's PO₂ of 57.7 (pre-exercise) and 63.7 (post-exercise) would be normal for a 77-year-old at an elevation of 6700 feet (Durango). Dr. James opined Claimant's exercise tolerance was decreased due to deconditioning and some component of ventilatory limitation. He opined that an FEV-1 of 84.8% was abnormal under the American Thoracic Society Guidelines. However, in looking at spirometry only, under the AMA guidelines Claimant would not have an impairment. Dr. James did not diagnose pneumoconiosis based on the chest x-rays he read. He opined that coal mine dust exposure was a significant contributing factor in the development of Claimant's COPD. He noted that COPD could also develop without any obvious cause or risk factor. He stated that he could not accurately assess whether Claimant would be able to perform his last coal mine employment.

On questioning by counsel for Claimant, Dr. James stated that respiratory impairment was reflected by the spirometry that showed moderate impairment on pre-bronchodilator studies and a more mild impairment on post-bronchodilator studies. Dr. James stated that he stood by his opinion that Claimant had COPD, moderate in severity, and that coal mining dust was a significant contributing factor to the COPD. He agreed that Claimant's coal mine dust related COPD had a materially adverse effect on his respiratory condition. He agreed after being read the exertional requirements of Claimant's job as bath house attendant that Claimant could have difficulties performing the more strenuous tasks of the position such as carrying a bucket of water. Dr. James opined that this would be due to a combination of deconditioning and COPD.

Miscellaneous Medical Records

Office Notes of Dr. Max Morgan

The office notes of Dr. Morgan appear at CX 6 and DX 12 and are dated August 3, 1995, through May 18, 1998, (DX 12) and April 7, 1999, through November 22, 2004 (CX 6). During this later period, Claimant was seen for his pacemaker follow-up, skin problems, iron-deficiency anemia, COPD and shortness of breath, fall with rib pain, and pneumonia. At his last visit on November 22, 2004, it was noted that Claimant's cough and congestion had resolved and that he no longer suffered from shortness of breath. On physical examination, Claimant had scattered rhonchi, a few wheezes, and slight decrease in breath sounds on the left. He was told to continue taking inhalers as prescribed.

Medical Records from Dr. Walter Snihurowych

The medical records from Dr. Snihurowych appear at DX 12. This physician treated Claimant from August 7, 1995, to August 28, 2001, for a variety of urological problems including prostate cancer.

Medical Records from Castlevue Hospital

Medical records from Castlevue Hospital appear at DX 12. Claimant was treated for hernia repair in March/April of 1998. In that same time period, Claimant had a pacemaker inserted due to long-standing bradycardia.

CONCLUSIONS OF LAW

Length of Coal Mine Employment

At the hearing, counsel for Employer stipulated to 25 years of coal mine employment. (TR 23-24.) The Director found in his proposed Decision and Order that Claimant had established 22 years of coal mine employment. (DX 32.) I find, based on Claimant's testimony, the Social Security records (DX 6), and information contained within his application for benefits (DX 2 and 3), that Claimant was a coal miner, within the meaning of the Act, for 25 years.

Date of Filing

Claimant filed his claim for benefits under the Act on February 15, 2002. (DX 2.)

Responsible Operator

Employer stipulated at the hearing that Energy West was the properly designated responsible operator in this case. (TR 24.) I find the evidence of record supports the conclusion that Energy West is the properly named responsible operator in this case. (DX 32; DX 40; DX 3.)

Dependents

I find that Claimant had one dependent, his wife, Carol until her death on July 13, 2005, for purposes of augmentation of benefits under the Act. (DX 2; TR 24-25.)

Standard of Review

In evaluating these types of claims, the administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his or her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra*; *Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. See *Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606 (1983); see also *Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); see also *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985).

As the trier-of-fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. See *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Entitlement: In General

To establish entitlement to benefits, a claimant must establish that he had pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that he was totally disabled, and that his total disability was due to pneumoconiosis.

Subsequent Claim/Employer's Motion to Dismiss Energy West as Responsible Operator

Pursuant to 20 C.F.R. § 725.309(d)(2001) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not

excluded in the adjudication of the prior claim. Moreover, if the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim.

Based on a memo to the file from the OWCP, dated December 16, 2003, Claimant apparently filed an earlier claim for benefits, while still working as a miner, on March 31, 1980. (DX 39.) Unfortunately the records from the first claim were destroyed. All that remained of the claim was a notation in a government computer that benefits had been denied. The memo also stated that while "evidence showed that Mr. Oliver had coal worker's pneumoconiosis arising out of his over-10 years of coal mine employment, the evidence did not show that Mr. Oliver was disabled by the disease at that time." No further action was taken on this claim and it was subsequently closed. (DX 39.)

In its closing brief, counsel for Employer moved that Energy West be dismissed as responsible operator in this case based on the principle that it was denied due process when the original claim file was destroyed. Employer's closing brief, page 2-3. Employer further argued that the claim be transferred to the Trust Fund for payment in the case of an award of benefits. Employer relied, at least in part, on the Sixth Circuit Court of Appeals case, *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000), in support of this position. Claimant did not file a reply to this motion. The Director did not respond.

Before I discuss *Holdman* and Employer's request for dismissal from the case, I will address the contents of the memo from the OWCP (DX 39) regarding the disposition of the first claim for benefits.

In the memo to the file from the OWCP, it is noted:

This file was retired to the Federal Records Center on December 8, 1983. It was destroyed in May 1999 in accordance with established record retention schedules. The 1980 claim is no longer open to adjudication.

(DX 39.)

I am not aware of any regulation that provides for the destruction of claim files in Black Lung cases. Nevertheless, the fact remains that the file was destroyed. All that is left is a computer entry in a government data base with no supporting documentation to verify the validity of the information. Moreover, we only have a memo to the file that summarizes that person's view of what was on the computer data base. The information contained within the memo is at least twice removed from the original source of the information (paper claim file) that is no longer available for examination. In addition, the statement in the memo regarding denial of benefits is vague. There is no accounting of exhibits, and, therefore, it is unknown what medical evidence was submitted in the first claim. It is not known what evidence was used to support a finding of pneumoconiosis and what evidence was used to ultimately deny benefits. I

find that the only reliable use of this memo is to provide documentation that a prior claim had indeed been filed.

The next issue is whether the conduct of the OWCP in destroying the case file necessitates the dismissal of Employer from the instant case.

In its brief, Employer relies, at least in part, on the Sixth Circuit Court of Appeals decision in *Holdman, supra*. In *Holdman*, the claimant was initially awarded benefits by an ALJ. This decision was based on a case file that contained evidence developed throughout the litigation process. Not satisfied with the decision, the employer filed a motion for reconsideration. The claim file was subsequently lost in the mail but the parties partially reconstructed the file and the ALJ denied employer's motion for reconsideration. Employer appealed. It was during the appeals process before the Benefits Review Board ("BRB" or "Board") that the loss of the claim file became an issue. The BRB concluded that it simply could not fairly evaluate the merits of the issues raised in the employer's appeal without access to the complete record. More than *ten years* after the file had gone missing, a frustrated ALJ found that it was the OWCP's repeated failures to comply with the BRB's orders to reconstruct the record that finally led to employer's dismissal of the case. The case was appealed and ultimately the Court of Appeals affirmed the ALJ's decision to dismiss the employer from the case, finding that Island Creek had been denied due process because the loss of evidence undermined Island Creek's ability to defend the claim.

Employer argues that the holding of *Holdman* is applicable in the instant matter. I disagree. First, this is a Sixth Circuit case which has no precedential value in the Tenth Circuit. Second, *Holdman* is clearly distinguishable from the instant matter. In *Holdman*, litigation spanned almost 16 years, 10 of which was spent trying to get the OWCP to reconstruct the record. In the instant matter, there has been no delay due to the missing case file. In *Holdman*, the court found that the employer was unable to defend its appeal to the Benefits Review Board without the complete record. Here, Employer has had a fair and full opportunity to defend this claim through its appearance and participation in the hearing and through the admission of its many physician reports and depositions into evidence. In addition, Employer has had every opportunity to submit rebuttal evidence in accordance with the regulations. Moreover, in *Holdman*, the case file, when it was lost, was an open, active file on appeal to the Benefits Review Board. In the instant matter, the 1980 claim file was administratively closed. Based on the foregoing, I find that the conduct of the OWCP in destroying a 25-year-old closed claim file in what was described as the agency's "standard practice" does not rise to the same level of ineptitude displayed in the *Holdman* case.

The final question is whether the due process rights of either party have been violated by the destruction of the original claim file. Employer argues that its due process rights have been violated since it is not able to have its physicians evaluate prior testing to determine whether Claimant's condition had materially worsened since the prior denial and that the reasons for the denial are not clear.

I agree that the reasons for the denial of the first claim are not clear (see discussion above), and for that reason the current claim will be decided on the newly submitted evidence. However, I disagree that these reasons rise to the level of a due process violation. Employer is in

the same position as Claimant in this situation. Employer and its medical consultants have access to the same medical evidence as Claimant. Moreover, from the outset of this litigation, Employer contested all four elements of entitlement. In fact, even after the memo from OWCP was issued Employer did not change or concede the existence of any element. Likewise, Claimant was on notice from the beginning that he would have to submit evidence in support of each element of entitlement, including the existence of pneumoconiosis, in order to succeed. There was a full and fair hearing at which both parties were represented. At that time each party presented a significant amount of evidence in support of their respective positions. Both were given the opportunity to argue their positions in the form of a closing brief. Therefore, based on the forgoing, I find that Employer's due process rights have not been violated. Accordingly, Employer's motion to dismiss is denied.

The Existence of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."¹⁰ The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.¹¹ 20 C.F.R. § 718.201. The term "arising out of coal

¹⁰ Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987).

¹¹ Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. (Emphasis added).

mine employment” is defined as including “any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”

Asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983).

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for “complicated pneumoconiosis” found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. § 718.201(a)(1).

A judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he or she deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

Of the submitted evidence, there are 19 interpretations of 15 x-rays. Out of these 19 interpretations, I accord less weight to the radiologists’ interpretations of the chest x-rays from September 6, 1995, (DX 12), August 9, 1996, (DX 12), March 3, 1998, (DX 12), March 4, 1998, (DX 12), April 1, 1998, (DX 12), October 5, 2004, (CX 6), October 6, 2004, (CX 6), October 7, 2004, (CX 6), and November 16, 2004, (CX 6). These x-rays were taken in hospital settings for the purpose of monitoring acute medical conditions, such as prostate cancer, pacemaker placement, and pneumonia, and were not taken for the purposes of assessing all potential lung conditions. Therefore, I find that the radiologists’ silence regarding pneumoconiosis does not necessarily mean that the disease was not present. See *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984).

The Board has held that it is proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.). In general, of the remaining 10 interpretations, 5 were read by dually qualified Board-Certified Radiologists and B-readers. Three interpretations were negative, one was read as positive for pneumoconiosis, and one was for film quality only. The positive chest x-ray was read by Dr. Lawrence. (DX 17.) In response to interrogatories sent by Employer, Dr. Lawrence indicated that these findings (1/2, s/s/, 4 zones) could be seen in CWP, asbestos workers, and polyvinyl-chloride workers and that these findings were not necessarily indicative of occupational pulmonary fibrosis. EX 14. Dr. Lawrence also stated that exposure history to other dusts and a smoking history would all be important factors in influencing findings on a chest x-ray. Dr. Lawrence noted he was sent the films with no history. I find that based on these statements, Dr. Lawrence did not have enough information about Claimant's dust exposure and smoking history in order to make a diagnosis of pneumoconiosis when he read the x-ray as 1/2. Accordingly, as the majority of dually-qualified interpretations are negative for pneumoconiosis, I find that Claimant has failed to establish, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Biopsy Evidence

A biopsy may be the basis for a finding of the existence of pneumoconiosis. § 718.202(a)(2). A finding in a biopsy of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis. § 718.202(a)(2).

There is no biopsy evidence in the record. Accordingly, I find that Claimant has failed to establish the presence of pneumoconiosis, by the preponderance of the evidence, pursuant to § 718.202(a)(2).

The Presumptions

If the presumptions described in §§ 718.304, 718.305 or 718.306 are applicable, it shall be presumed that the miner is or was suffering from pneumoconiosis. § 718.202(a)(3).

Initially, I note that Claimant cannot qualify for the § 718.305 presumption because he did not file this claim before January 1, 1982. Claimant is also ineligible for the § 718.306 presumption because he is still living.

Moreover, Claimant is ineligible for the § 718.304 presumption as there is no credible evidence that Claimant suffers from complicated pneumoconiosis.¹²

Since none of the foregoing presumptions are applicable in this matter, I find that Claimant has failed to establish the presence of pneumoconiosis pursuant to § 718.202(a)(3).

¹² Complicated pneumoconiosis is established by x-rays classified as Category A, B, C, or by an autopsy or biopsy that yields evidence of massive lesions in the lung. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the administrative law judge must consider and weigh all relevant evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991). None of the physicians who rendered an opinion in this case diagnosed the presence of complicated pneumoconiosis. Therefore I find this presumption is not applicable.

Medical Opinion Evidence

Additionally, a determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a). Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Smoking History

In general, in order for physicians to arrive at a proper, reasoned diagnosis, it is essential that they be presented with an accurate picture of a patient's complaints, prior medical history, working or environmental conditions, and social habits, including smoking. See *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986) (An opinion may be given less weight where the physician did not have a complete picture of the miner's condition.)

Specifically, in Black Lung cases, a claimant's smoking history is of particular importance. This is because the pulmonary manifestations of smoking are often similar to that of coal workers' pneumoconiosis.

Regarding Claimant's smoking history, the medical records consistently state that Claimant was never a smoker. (DX 13; EX 2; EX 4; CX 1.) Accordingly, in evaluating the evidence, I will consider Claimant to have a negative smoking history.

Analysis of Medical Opinions

In the instant matter, the opinions of five physicians were submitted regarding Claimant's medical condition. In general, Dr. Poitras found Claimant had a mild to moderate obstructive disease and that Claimant's 17 years of coal mine dust exposure was a significant, but partial, contributing factor to the obstructive lung disease. (EX 13.) Likewise, Dr. Morgan opined Claimant had COPD that was significantly related to his dust exposure in his coal mine employment. (EX 12.) Dr. James stated that coal mine dust exposure was a significant contributing factor in the development of Claimant's COPD. (EX 15.) Dr. Farney opined Claimant had COPD consistent with asthma or reactive airway disease and was not related to Claimant's "quite minimal" coal mine dust exposure. (EX 2; EX 16.) Dr. Fino concluded Claimant had a mild reversible obstructive impairment due to asthma and not from coal mine dust exposure. (EX 4.)

It is interesting to note that all five physicians agreed that the radiographic evidence in this case did not support a diagnosis of clinical pneumoconiosis. I find that this conclusion is also supported by the CT scan evidence. In general, the CT scan evidence was compatible with

COPD but negative for pneumoconiosis. Moreover, all five physicians agreed that Claimant suffered from some degree of obstructive impairment. The difference in opinion was the cause of the obstructive defect.

In order to establish the presence of legal pneumoconiosis, Claimant must show that the obstructive defect was significantly related to, or substantially aggravated by, dust exposure in coal mine employment. With that definition in mind, I turn to the various medical opinions in this matter.

In general, more weight may be accorded to the conclusions of a treating physician as he is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989).

Section 718.104(d) codifies the "treating physician rule" and provides the following list of factors in weighing the opinion of the miner's treating physician: (1) nature of the relationship, (2) duration of the relationship, (3) frequency of the treatment, and (4) extent of treatment. The record contains the medical report (CX 2), deposition testimony (EX 12), and treatment records of Dr. Morgan (CX 6).

Claimant testified that Dr. Morgan had been his treating physician since 1995. (TR 49.) Dr. Morgan is a family practice physician and treated Claimant for shortness of breath, respiratory distress, wheezing, and recurrent upper respiratory tract infections. (CX 2.) Dr. Morgan noted that he treated Claimant on a frequent basis and attended to Claimant during hospitalizations. (EX 12.) Based on the foregoing, I find Dr. Morgan was in a unique position to render an opinion in this matter and, if found credible, his opinion may be entitled to controlling weight in this matter. 20 C.F.R. § 718.104(d)(5)(2001).

I accord great weight to the opinion of Dr. Morgan on this issue. Dr. Morgan opined that Claimant's obstructive lung defect was due, at least in substantial part, to 22 years of coal dust exposure. In addition to being Claimant's treating physician, I find that his opinion is well-reasoned and well-documented and is consistent with the objective evidence in the record that showed the presence of an obstructive defect. In addition, his opinion is consistent with Claimant's subjective complaints of productive cough and shortness of breath, recurrent history of pneumonia, Claimant's history of coal mine employment, and negative smoking history. Based on the foregoing, I accord the opinion of Dr. Morgan great weight on this issue.

Likewise, I accord great weight to the highly qualified opinions of Drs. Poitras and James. Dr. Poitras is Board-Certified in Internal Medicine, and Dr. James is Board-Certified in Pulmonary Disease and Internal Medicine. Both agreed that Claimant's exposure to coal mine dust was a significant contributing factor to the development of COPD. I find that the opinion of Dr. James is well-reasoned and well-documented and consistent with Claimant's history of 20 years of shortness of breath, productive cough, and the presence of an obstructive defect on spirometry. Dr. James stated the reasons for his conclusion and noted that asthma was an unlikely explanation for Claimant's respiratory changes for the following reasons: (1) Claimant's airflow limitation persisted despite bronchodilator challenge, and (2) the volume of phlegm production would be unusual for an individual with only asthma. Moreover, this opinion was consistent with the opinion of Claimant's treating physician, Dr. Morgan, who did not diagnose

Claimant as having asthma. Dr. James also pointed out that chronic exposure to coal dust was a risk factor for developing COPD and that there were no other occupational exposures that would have contributed to Claimant's development of chronic pulmonary disease.

I also find the opinion of Dr. Poitras to be well-reasoned and well-documented and consistent with the pulmonary function studies, results of the physical examination, Claimant's occupational history of coal mine employment, negative smoking history, and the absence of other significant exposures. Dr. Poitras acknowledged that there were other contributing factors to Claimant's COPD such as chronic aspiration and the fact that Claimant was a rancher, but he added that coal mine dust exposure played a significant role in the development of the disease. Moreover, his opinion is consistent with the highly persuasive opinions of Drs. James and Morgan.

Conversely, I accord less weight to the highly qualified opinions of Drs. Farney and Fino. First, I find the opinion of Dr. Farney is not well-reasoned. Dr. Farney indicated in his medical report that Claimant worked for 24 years in the coal mine industry but that the last 5-6 years were spent working as an attendant in the bath house. At his deposition Dr. Farney disagreed that Claimant had sufficient coal mine dust exposure to develop COPD noting that Claimant's exposure was "quite minimal." (EX 16.) However, Claimant testified at the hearing regarding the conditions at the coal mines where he worked. Claimant stated that he worked all but the last 5-6 years in underground coal mines. He worked first as a shuttle car operator at the face of the mine, and then as a belt man. (TR 39-42.) Even in the bath house Claimant noted that there was a lot of coal dust flying around. The coal dust from the miner's clothes and boots accumulated in the areas he cleaned, and coal dust accumulated on his clothes and body. (TR 44-46.) In addition, a witness for Claimant, Mr. McElprang described the conditions of the mines where he and Claimant worked, noting that it was so dusty that the mine operator could not see the shuttle car by the time it was loaded with coal. (TR 68-69.) Mr. McElprang also noted that the bath house was a filthy place and that coal dust was everywhere. (TR 72.)

I find the testimony of Claimant and Mr. McElprang to be both credible and convincing. Therefore, I find, based on the forgoing, that out of Claimant's 25 years of coal mine employment, Claimant worked approximately 19 years in underground coal mines where he was exposed to moderate to heavy amounts of coal mine dust on a regular basis. I also find that Claimant worked the last 5-6 years in the bath house where he was exposed to a relatively light amount of coal mine dust. Accordingly, Dr. Farney's characterization of Claimant's coal mine dust exposure as being "quite minimal" simply is not credible. Dr. Farney offered no persuasive evidence or argument that Claimant's 19 years of underground coal mine employment, some of it at the face, would amount to a minimal exposure. Moreover, no other physician in the record described Claimant's dust exposure as being minimal. Even considering Claimant's last employment in the bath house, Claimant's exposure to coal mine dust was more than minimal based on the persuasive testimony of Mr. McElprang. Because Dr. Farney based his conclusion (i.e. that Claimant did not have sufficient coal mine dust exposure to be a factor in the development of the COPD) on a premise (i.e. Claimant's coal mine dust exposure was minimal) contrary to the findings of this opinion (i.e. Claimant had a significant history of coal mine dust exposure), I accord his opinion less weight on this issue.

Likewise, I accord the opinion of Dr. Fino less weight. Dr. Fino did not examine

Claimant but conducted a medical records review. Dr. Fino opined that Claimant's mild reversible impairment was due to asthma and not coal mine dust. Dr. Fino stated the reasons for his diagnosis and pointed to objective medical evidence in support of his opinion. Dr. Fino's diagnosis of asthma is contrary to the findings of Drs. Morgan, James, and Poitras. As noted above, I found the opinion of all three of these physicians to be highly credible and persuasive. So, on one hand is the well-reasoned, well-documented report of Dr. Fino and on the other are the well-reasoned, well-documented reports of Drs. Poitras, James, and Morgan. As I found earlier, Dr. Morgan was Claimant's treating physician and had the benefit of observing and evaluating Claimant's condition on a regular basis over a lengthy period of time. Moreover, his opinion was corroborated by Drs. James and Poitras. Conversely, since the opinion of Dr. Farney has already been given less weight on this issue, the opinion of Dr. Fino is not corroborated by any other credible medical opinion evidence in this case. In weighing these opinions, I find that the opinion of Dr. Morgan, corroborated by Drs. James and Poitras, outweighs the opinion of Dr. Fino.

Based on the foregoing discussion, I find Claimant has established the existence of pneumoconiosis pursuant to § 718.202(a)(4).

Cause of Pneumoconiosis Pursuant to 718.203

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for 10 years or more in the coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

I find that Claimant, with 25 years of coal mine employment, would be entitled to the rebuttable presumption at § 718.203.

However, in the recent case of *Anderson v. Director, OWCP*, ___ F.3d ___ (10th Cir. 2006) (decided July 25, 2006, No. 05-9550) the court held that because a claimant suffering from chronic obstructive pulmonary disease (COPD) must prove his COPD arose out of coal mine employment to prove he suffers from legal pneumoconiosis, this rebuttable presumption that claimant's lung disease arose out of coal mine employment does not extend to cases of COPD. Because this is such a case, I find this element is moot since Claimant has already established his COPD arose out of his coal mine employment under the analysis for pneumoconiosis.

Evidence of Total Disability

A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner from performing his usual coal mine work or comparable employment. § 718.204(b)(1). Section 718.204 sets out the standards for determining total disability. This section provides that in the absence of contrary probative evidence, evidence that meets the quality standards of the subsection shall establish the miner's total disability.

Subsection 718.204(b)(2)(i) provides that total disability may be established by pulmonary function testing. There are five pulmonary function studies submitted as part of

Claimant's claim for benefits. Only the pre-bronchodilator values from the February 10, 2004, test were qualifying. This study was subsequently invalidated by Dr. Renn, who is Board-Certified Internal Medicine and Pulmonary Disease. (EX 9.) There is no rebuttal to Dr. Renn's report in the record. As none of the credible studies were qualifying under the Act, I find that Claimant has failed to establish total disability under § 718.204(b)(2)(i).

Subsection 718.204(b)(2)(ii) provides that qualifying arterial blood gas testing may establish total disability. There are three arterial blood gas studies in the record. The arterial blood gases from April 26, 2002, were qualifying and the exercise values in the May 6, 2005, test were qualifying under the Act. Because the evidence is at best equivocal (one qualifying study/one non-qualifying study/one study with qualifying exercise values and non-qualifying resting values), I find that Claimant has failed to establish total disability pursuant to § 718.204(b)(2)(ii).

There is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure pursuant to § 718.204(b)(2)(iii).

Subsection 718.204(b)(2)(iv) provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluded that Claimant's respiratory or pulmonary impairment prevents him from engaging in his usual coal mine work or in comparable and gainful employment.

There are five physicians who have rendered an opinion in this matter relative to this issue. Dr. Poitras opined that Claimant's obstructive defect coupled with a low PO₂ would make physical activity such as that required of a mine/laborer impossible and make Claimant 100% disabled. (DX 13.) Likewise, Dr. Morgan opined Claimant did not retain the pulmonary capacity to perform the duties of a bath house attendant. (EX 12.) Dr. James concluded Claimant could have difficulties performing the more strenuous tasks of the position. (EX 15.) Conversely, Dr. Farney stated that Claimant would not be impaired from working due only to pulmonary disease. (EX 3.) Dr. Fino concluded Claimant had adequate lung function to perform the duties of bath house attendant.

First, I note that the job description of Claimant's last coal mine job as bath house attendant appears at CX 8. From 1986 to 1993 Claimant worked in the bath house. As part of his duties he was responsible for cleaning the bath house including the showers and changing areas. His duties included mopping floors and carrying buckets of water weighing 20 pounds. He also scrubbed showers, sinks, toilets, windows, and mirrors. He was the only attendant on duty, and 100-200 miners would use the bath house per shift. Claimant was responsible for carrying trash bags weighing 50 pounds to the garbage area and had to stock pile boxes of soap weighing 30-40 pounds. Claimant would shovel snow when needed and was on his feet the entire shift. (CX 8.) Claimant's testimony at the hearing corroborated this statement.

I find based on the foregoing that the exertional requirements of Claimant's last coal mine job as bath house attendant were moderate with occasional periods of heavy labor. With that in mind, I turn to the analysis of the medical opinions.

I accord less weight to the opinion of Dr. James on this issue. I find that his opinion is equivocal and, therefore, is less credible. Initially in his medical report, Dr. James stated that he could not determine whether Claimant would be unable to perform his usual coal mine employment as a consequence of his lung disease. (CX 1.) At his deposition, he rated the exertional requirements of the bath house position as mild to moderate and noted that this job could be performed with some pulmonary impairment (possibly suggesting no total disability due to a pulmonary impairment). He then concluded that he could not accurately assess whether Claimant would be able to perform his last coal mine employment. On questioning by counsel for Claimant, Dr. James opined that Claimant could have difficulties performing the more strenuous tasks of the position such as carrying a bucket of water, due to a combination of deconditioning and COPD (possibly suggesting the presence of a total disability due to a pulmonary impairment). (EX 15.) After maintaining in his medical report and at the deposition that he could not decide the issue, he seemed to concede certain facts in favor of each party. Overall, I am not certain what his final opinion is on this issue. Therefore, I find based on the foregoing that the opinion of Dr. James on this issue should be accorded little weight.

I accord great weight to the opinions of Drs. Morgan and Poitras on this issue. Again, I note that Dr. Morgan is Claimant's treating physician and as such will be deemed to have special knowledge of Claimant's condition if his opinion is found to be credible.

I indeed find that the opinion of Dr. Morgan is well-reasoned and well-documented on this issue. He opined Claimant did not have the pulmonary capacity to perform the duties of the bath house attendant. He noted that while Claimant's FEV-1 improved after bronchodilators, it was still abnormally low reflecting a respiratory impairment. He added that Claimant would become short of breath walking from his car to his office and that what was seen on paper did not really indicate what someone could do as far as physical capability. I find this assertion by Dr. Morgan to be compelling. I also find that a personal observation, such as this, is one reason why the opinion of treating physicians can be extremely valuable and important. They say something about the Claimant that cannot be found in a set of cold, hard numbers. For these reasons, I find the opinion of Dr. Morgan to be very persuasive and will be accorded great weight.

Likewise, I accord great weight to the opinion of Dr. Poitras on this issue. His opinion is well-reasoned and well-documented and is consistent with Claimant's subjective complaints of shortness of breath on exertion, the vent studies that showed the presence of a mild to moderate obstructive defect, the exertional requirements of Claimant's last coal mine position as a bath house attendant, and the low arterial blood gas values. For these reasons, I accord the opinion of Dr. Poitras great weight on this issue.

Conversely, I accord less weight to the opinions of Drs. Fino and Farney. Dr. Farney opined that Claimant retained the pulmonary capacity to perform the duties as bath house attendant. I find that the opinion of Dr. Farney is not well-reasoned. He testified at his deposition that the exertional requirements of Claimant's position as bath house attendant would be fairly minimal. This opinion is contrary to the findings of this opinion that the exertional requirements of the bath house job would be moderate with periods of heavy labor. Moreover, I find his conclusion is not consistent with Claimant's subjective complaints of shortness of breath on exertion, the fact that Claimant was on supplemental oxygen, the results of the April 26, 2002,

and May 6, 2005, (post-exercise) arterial blood gases that were qualifying under the regulations for disability, and vent studies that showed the presence of a mild to moderate obstructive impairment. I find that Dr. Farney failed to adequately explain how a patient who, according to Dr. Morgan, became short of breath just walking from his car to the office, could perform the duties of a bath house attendant for an entire shift. Based on the foregoing, I find the opinion of Dr. Farney not credible and therefore accord his conclusions less weight on this issue.

Likewise I accord less weight to the opinion of Dr. Fino. Dr. Fino acknowledged, consistent with this opinion, that the exertional requirements of the bath house position would be moderate with bursts of heavy labor. However, he concluded that based on spirometry, lung volumes, diffusing capacity, and exercise tests, that Claimant had a mild reversible obstruction that would not prevent him from performing considerable labor. I find Dr. Fino's opinion unconvincing. I find that his opinion is not consistent with Claimant's subjective complaints of shortness of breath on exertion and low oxygen levels that required him to be on supplemental oxygen 24 hours per day. Moreover, the April 26, 2002, and May 6, 2005, (post-exercise) arterial blood gas studies produced qualifying values for disability under the regulations. Dr. Fino maintained that these values were normal when corrected for age and altitude. I am skeptical of an opinion that declares as "normal" values that are qualifying for disability under the regulations. Based on the foregoing concerns, I find that the well-reasoned, well-documented opinions of Drs. Morgan and Poitras outweigh the opinion of Dr. Fino.

Accordingly, based on the foregoing, I find Claimant has established total disability pursuant to § 718.204(b)(2)(iv).

In weighing all of the foregoing, I find Claimant has established the existence of a totally disabling respiratory impairment pursuant to § 718.204(b).

Disability Causation

The final issue is whether Claimant has established disability causation under § 718.204(c)(1).

Pursuant to § 718.204(c)(1) a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

- (i) Has a material adverse effect on the miner's respiratory or pulmonary condition;
or
- (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

There are four physicians who have rendered an opinion on this issue.¹³ Dr. Poitras stated that Claimant's coal mine dust exposure was a significant contributing factor to Claimant's respiratory disability. Dr. Morgan stated that Claimant's COPD (that was significantly related to coal mine dust exposure) made a strong contribution to Claimant's inability to perform his last coal mine job. Drs. Farney and Fino opined there was no totally disabling pulmonary impairment.

I accord greater weight to the opinions of Drs. Poitras and Morgan who found the presence of legal pneumoconiosis and concluded that Claimant was totally disabled from performing his last coal mine employment due to a pulmonary impairment caused by coal mine dust exposure. As explained earlier, I find the opinions of Drs. Poitras and Morgan to be well-reasoned and well-documented. For this reason, I accord the opinion of Drs. Poitras and Morgan great weight.

Conversely, I accord less weight to the opinions of Drs. Farney and Fino who found, contrary to the findings of this opinion, that Claimant did not have a totally disabling pulmonary impairment and that Claimant did not have pneumoconiosis. *Trujillo v. Kaiser Steel Corp.*, 8 B.L.R. 1-472 (1986). For this reason, I accord their opinions less weight on this issue.

Accordingly, I find Claimant has established, by the preponderance of the better-reasoned evidence, his total disability was due to coal worker's pneumoconiosis pursuant to § 718.204(c).

CONCLUSION

Because Claimant has established all elements of entitlement, I conclude that he has established entitlement to benefits under the Act.

Date of Onset

In a case where evidence does not establish the month of onset, benefits shall be payable beginning with the month during which the claim was filed. 20 C.F.R. § 725.303(d). In the instant matter, Claimant filed his claim on February 15, 2002. (DX 2.)

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §§ 725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have 10 days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

¹³ Because the opinion of Dr. James regarding the presence of a totally disabling pulmonary impairment is vague (see discussion *infra*), any opinion he may have regarding the etiology of said impairment is accorded less weight.

ORDER

The claim of J.L.O. for black lung benefits under the Act is hereby GRANTED, and

It is hereby ORDERED that ENERGY WEST MINING, INC., the Responsible Operator, shall pay to the Claimant all augmented benefits to which he is entitled under the Act, commencing February 1, 2002. The augmentation of the dependant wife's benefits shall run from February 1, 2002, to July 13, 2005 (date of wife's death).

A

JENNIFER GEE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).